DOCUMENT RESUME

ED 332 420 EC 300 282

AUTHOR	Mason, James L.; Young, Thomas M., III
TITLE	Therapeutic Case Advocacy Trainers' Guide: A Format for Training Direct Service Staff and Administrators. Therapeutic Case Advocacy Project.
INSTITUTION	Portland State Univ., OR. Research and Training Center on Family Support and Children's Mental Health.
SPONS AGENCY	National Inst. of Mental Health (DHHS), Rockville, MD.; National Inst. on Disability and Rehabilitation Research (ED/OSERS), Washington, DC.
PUB DATE	Jun 90
CONTRACT	G0087C0222-88
NOTE	59p.; For related documents, see EC 300 281.
PUB TYPE	Guides - Classroom Use - Teaching Guides (For Teacher) (052) -- Tests/Evaluation Instruments (160)
EDRS PRICE	MF01/PC03 Plus Postage.
DESCRIPTORS	*Agency Cooperation; *Child Advocacy; Community Resources; *Delivery Systems; *Emotional Disturbances; Family Involvement; Family Programs; Individualized Programs; Interdisciplinary Approach; Intervention; Models; Organizational Development; Program Development; Program Evaluation; Resources; Teamwork; Training Methods
IDENTIFIERS	Case Management

ABSTRACT

This guide assists in establishing a collaborative unit or a task group to deliver services to children and youth with serious emotional disabilities and their families. The guide is not intended to be an exhaustive manual, but does address the primary activities of professionals using interagency collaboration to establish comprehensive systems of care. The guide creates a system of care using a therapeutic case advocacy approach, considering three components (case advocacy, interpersonal interventions, and case management) at three levels (interagency organizational, and case levels). Activities and exercises are presented for four training goals: (1) understanding emotional disorders; (2) creating the individualized system of care; (3) resource identification and development; and (4) applying the components of the model. An appendix contains forms useful in evaluating whether the therapeutic case advocacy model produces changes over time in the expectations, instructions, supports, and rewards of designated behavior settings within the children's environment. The forms gather data based on environmental characteristics, children, unit participants, the service team, and parents. (Five references) (JDD)

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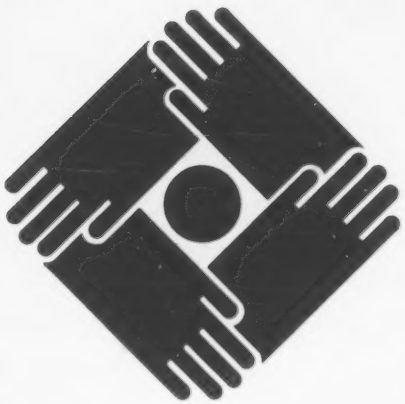
Therapeutic Case Advocacy Trainers' Guide: A Format for Training Direct Service Staff and Administrators



Therapeutic Case Advocacy Project
Research and Training Center on Family Support
and Children's Mental Health
Portland State University

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Therapeutic Case Advocacy Trainers' Guide: A Format for Training Direct Service Staff and Administrators

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June 1990

The recommended citation of this publication is:

Mason, J.L. & Young, T.M. (1990). *Therapeutic Case Advocacy Trainers' Guide: A Format for Training Direct Service Staff and Administrators.* Portland, OR: Portland State University, Research and Training Center on Family Support and Children's Mental Health.

This publication was developed with funding from the National Institute on Disability and Rehabilitation Research, United States Department of Education, and the National Institute of Mental Health, United States Department of Health and Human Services (NIDRR grant number G0087C0222-88). The content of this publication does not necessarily reflect the views or policies of the funding agencies.

ACKNOWLEDGMENTS

Many individuals have been instrumental in the development of this model. The Child and Adolescent Service System Program leadership and state project directors must be acknowledged for their critiques and suggestions regarding model development. The agencies and organizations that participated in training must also be credited for their willingness to consider new approaches to improving service delivery to children, youth, and their families.

Thanks must be extended also to the Oregon Children's Services Division, particularly to Multnomah County branch workers and administrators, who allowed the model to be piloted in their agency. We appreciate our local advisory board for their support in helping to break down barriers between agencies and disciplines, which is essential to implementing the model.

Similarly, the wisdom of the Center's National Advisory Committee must be acknowledged, as their advice was indispensable to development of the model and its training materials.

Finally, we would like to salute the many children and families and those who work on their behalf for inspiring our work and giving us the confidence to develop a new concept of delivering comprehensive children's mental health treatment.

James L. Mason, Project Manager

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INTRODUCTION

The Therapeutic Case Advocacy Trainer's Guide is an aid for trainers, managers, administrators, and other professionals for establishing a collaborative unit or a task group to deliver services to children and youth with serious emotional disabilities and their families. This guide is not an exhaustive manual, but points to some major issues to be considered when utilizing the model. It does address the primary activities of professionals using interagency collaboration to establish comprehensive systems of care for children and their families.

This document is a product of the Therapeutic Case Advocacy Project of the Portland Research and Training Center on Family Support and Children's Mental Health. It is supported by several other project materials, including:

- an annotated bibliography on case advocacy,
- an annotated bibliography on therapeutic interventions,
- an annotated bibliography on interagency collaboration,
- an article by the principal investigator, Thomas M. Young, III, Ph.D., describing the concept,
- a worker's handbook, and
- the final report of the project's activities.

ACTIVITY I TRAINING GOAL:
Understanding Emotional Disorders

OBJECTIVE

To help workers understand and recognize their own importance and that of others in the child's environment.

ASSUMPTIONS

1. Emotional disorders can be viewed more productively as an affective and behavioral reaction to unmanageable discrepancies between a child's capabilities and environmental demands and resources. Particularly, what is expected of the child and what is provided in terms of instruction, support and reward; and,

2. Cure, or more appropriately, adjustment or adaptation is achieved by the provision or arrangement of more manageable environmental conditions.

DISCUSSION

Often children and youth who are emotionally troubled do not respond in ways professionals expect or find gratifying. As a result, professionals may become impatient, frustrated or disappointed in their failure to "get through" to the emotionally troubled child. Parents' feelings are compounded by the loss of hopes and dreams for their child that often begin forming before the birth of the child.

Most clinical approaches to working with children and youth begin with an assessment or diagnosis explaining the child's "differentness"; this leads to a treatment plan that typically attempts to change the child in a certain way.

Therapeutic Case Advocacy is an alternative approach that tries to change the child's environment, which may or may not lead to some corresponding change in their overt behavior or emotional experience. Therapeutic Case Advocacy is designed to be a "multi-level" approach because changing environments may require multi-agency or multi-level activities. The goal is to reorganize, restructure or modify the child's environment so that all behavior settings function in concert as a case level system of care. Ultimately, providers have more consistent expectations, and are more consistent in providing instruction, support and reward which are better attuned to the child's capacities.

TRAINER NOTES

In 1980, the World Health Organization (WHO) published the *International Classification of Impairments, Disabilities and Handicap.* This work defined each of these terms on the basis of the level of disturbance in function. The first level of disturbance is an impairment, "any loss or abnormality of psychological, physiological, anatomical structure, or function" (WHO, p. 27). Ordinarily, impairments are not an obstacle to normal daily living, although this depends on the environmental context.

For example, a child with a fear of dogs may have his sleep disrupted by nightmares of dogs chasing him. But if he lives in an urban high rise apartment and takes a bus to school, this psychological impairment does not present an obstacle to normal daily living. Changing his environment to a suburban or rural setting could create severe consequences in impairing his functioning.

A disability is "any restriction or lack resulting from an impairment or ability to perform an activity in the manner or within the range considered normal." (WHO, p. 28). A disability refers to a departure from the norm in terms of performance customarily expected. However, if the environment accommodates the disability by creating a special role for the individual, then the functional consequences of the disability do not present an obstacle to that person's participation and integration in the environment. For example, a child with a pervasive developmental disorder exhibiting schizoid features might not be able to deliver a normal performance in the typical classroom. He most likely would find the patterns of social interaction overstimulating and disorganizing to the point where he has to disrupt it or seek isolation for his own psychological comfort and cohesion. If the school were able to construct a special cubicle within this classroom and assign a teacher's aide to work with him, he might be able to remain in the classroom environment and perform within the expected academic range. If this kind of arrangement cannot be made, or if it can be and he still cannot perform within the expected range in this arrangement, then his emotional disability prevents the "fulfillment of a role that is normal...for that individual" and he is said to have a "handicap." *Handicap is thus a social phenomenon representing the social and environmental consequences stemming from the presence of impairments and disabilities* (WHO, p. 29).

An emotional disability, then, is the result of a discrepancy between the child's capacities and the demands and expectations of the environment (Chess and Thomas, 1984:21). Whenever the environment does not adjust its demands and expectations to the individual's capacities, he or she is disabled.

Revising the conventional notion of emotional disorders, from focusing on the child to the fit between the child and his/her environment, has a rather significant implication. The implication is that efforts to help children with emotional disabilities might be more productive in focusing on the environment-as-solution, instead of on the child-as-problem.

A comprehensive discussion of the second assumption could command a separate paper in itself. The point is that cure--at least in its conventional meaning--is not central; it is epiphenomenal, a secondary effect of a recalibrated relationship between the child and his or her environment. And it may not happen at all. The emotional disability--the affective and behavioral reaction to unmanageable environmental conditions--may endure despite environmental changes in those conditions that are beneficial in other ways. An adolescent with a schizophrenic mental disorder may continue to experience anxiety, despite successful efforts to enroll him in a special educational setting and to allow him to live at home rather than in an institutional setting. But the social and environmental consequences stemming from the mental disability are minimized, if not removed completely. Of course, the adjusted expectations, instructions, supports and rewards of the two recalibrated environmental contexts may lead to reduced anxiety and perhaps to a modulation of the schizophrenic symptomatology itself.

Replacing the concept of emotional disturbance with that of emotional disability encourages design and manufacture of more accommodating environments for these children. This perspective emphasizes the use of treatment activities to develop individual potential. The concept of emotional disturbance tends to lead to deficit-reduction types of treatment activities which are limiting. We are reminded here of one parent's objection to "teaching life skills" as our goal in helping children with emotional disabilities. It inhibits our consideration of what these children might accomplish if their environments assisted them in meeting the particular challenges they present.

If we shift our emphasis from child-as-problem to environment-as-solution, the opportunity for reducing the degree of disability will increase for many children. In part, this will result from involving children and/or their families in the process of modifying their environment. This change in emphasis offers promising alternatives for the organized provision of mental health services.

EXERCISES FOR ACTIVITY 1:
Understanding Emotional Disorders

QUESTIONS FOR DISCUSSION OF VIGNETTES

1. In your own words, describe how (Dave, Ellen, Ben)'s situation would be disturbing to you emotionally if you were him/her?
2. Identify what is confusing or missing in the situation in terms of the expectations, instructions, supports and rewards that he/she has to work with.
3. How would you attempt to modify the expectations, instructions, supports, and rewards provided by the environment to lessen the emotional disturbance?

PROFILE: **Dave**

Imagine that you are a 30-year-old man who has made a recent mid-life career change and successfully obtained a Masters degree in Social Work or Counseling. You are eager to do well in your new job. The supervisor you are assigned to is a 35-year-old man who informs you in your first (weekly) supervisory session that after years of feeling ashamed and guilty about being gay, he has come out. He tells you that he feels like he's got a new lease on life, but is disappointed at how many of his fellow social workers are so openly homophobic. In each succeeding supervisory session, he manages to shift the conversation away from your cases and questions to some topic related to gayness and social reactions to it. How would you feel about this and what, if anything, would you try to do about it?

PROFILE: **Ben**

Imagine that you are 43 years old and have done quite well at your occupation without ever having completed college. Due to a reorganization of your agency, you must now either return to complete your college degree (and be promoted) or be let go. The one remaining course is a speech class. You never took it in the first place because you are and always have been a shy person. But you register and discover that to pass the course, you must actually give three speeches to the class--one that has over 60 students. You seek the help of your spouse/partner/best friend because he or she is a very good public speaker. But you are denied the help and are told that you will have to suffer through it and learn to do it on your own, just the way he or she did it. How would you feel and what would you try to do about it?

PROFILE: **Ellen**

Imagine that you are a 23-year-old white female, and your employer has required you to complete a twelve weekend (once per month) training course in Substance Abuse and the Recovery Process. This is not something that you want to do, but you must. You have to travel to and from a nearby city each weekend for the training; all the other trainees are either recovering addicts/alcoholics or members of a racial/ethnic minority group; and the trainer (a recovering heroin addict) uses an experiential/confrontational approach. How would you begin to feel each Friday afternoon and what, if anything, would you try to do about it?

ACTIVITY II TRAINING GOAL:
Creating the Individualized System of Care

OBJECTIVE

To help workers design individualized systems of care based on the needs and strengths of children and youth with emotional disabilities.

ASSUMPTIONS

1. Therapeutic Case Advocacy is an approach dedicated to creating and maintaining systems of care for children, youth and their families. However, it is important to emphasize that systems of care should be organized around the needs of children with emotional disabilities and their families, instead of the existing array of services available;

2. In developing viable systems of care, an intensive assessment must be conducted. While many workers are able to discern dysfunction, identifying assets is more problematic. For example, many children with emotional disabilities do not present problems in every behavior setting, nor is every behavior setting as problematic as the next. The assessment process must be able to discern the type of setting in which the child will perform best and to generalize these interaction patterns to other settings. These strengths may lie in interactions with family or extended family members, caregivers, clergy, or natural helpers. There are any number of potential settings in which the child performs up to expectation, but these settings are often overlooked because they are not a part of a formal agency or system and are not considered problematic;

3. In applying Therapeutic Case Advocacy to direct work with the child and family, there are three characteristics of each behavior setting that must be examined: the instructions, supports and rewards for behavior expected. If these are not compatible with the child's own goals, talents and evolving skills, then the setting is contributing to the child's emotional disability (Kohut, 1980). The disabling characteristics of a setting may be modified to make it more manageable for the child and less emotionally troubling. This can be achieved by modifying expectations to match the child's ambitions, providing support for attaining goals, giving instructions based on the child's skill level, and rewarding genuine attempts to improve skills, and;

4. To be effective, the system of care must include both services from formal organizations and help from the child's, family's, or community's natural networks of support. At the state or systems level, systems of care represent the array of services needed to serve all children and youth, but at the case level, these systems become quite specific. This specificity or individualizing of care requires a thorough assessment.

DISCUSSION

Ecological assessments are used to organize our understanding of the difficulties facing children, youth, and their families. These assessments are also used to discern assets of the child, youth and family upon which our interventions can be anchored. The former concern represents needs or deficits and the latter represents strengths the child and family have. Strengths are difficult to discern, particularly for line level workers who labor in the trenches to help troubled children and families on an everyday basis. Comprehensive service planning requires such assessments to individualize service delivery. As a result, ecological assessment places greater emphasis on the types of environmental conditions, services, resources and helpers needed for the child and family to function more effectively.

The assessment is ecologically-oriented because individuals who have emotional disabilities (as any individual) may be substantially affected by environmental conditions, logistics and individual-environment transactions. The unit of classification is not the child per se, but the child and the specific behavior settings in which he or she engages. The assessment must also be service-oriented and multidisciplinary, so that it is useful to those who provide a service or resource to children, youth and their families.

Assessments aid in developing a collaborative and coordinated service plan for a child and family. Two aspects result from the TCA assessment process: (1) the ecological assessment; and (2) an enablement plan. Together they represent:

> ...a systematic audit of assets and deficits in the child's ecosystem (again with respect to service needs) which involves: 1) identifying sources of discord in the ecosystem and sources of strength that can be used to improve the goodness-of-fit between the child and important people and places; and, 2) specifying what services are needed to assure that the child will be able to make reasonable progress toward achievable developmental goals. (Hobbs: 1982, p. 195-199.)

While it is not always possible to cure a child or youth, the environments (or system of care elements) can be structured to better reflect the child's specific capabilities. Improvement in the child's functioning may be achieved by effecting changes in the child (e.g., through psychotherapy), but may also be achieved by changing the system of care elements and behavior settings in which a child is expected to grow and learn, particularly in the expectations of the child and provision of instruction, support and reward.

EXERCISES FOR ACTIVITY II:
Creating the Individualized System of Care

INDIVIDUALLY,

After reading the vignette, please:

1. Identify the problems facing the child and/or the family;
2. Prioritize the problems and begin to list the various treatment needs;
3. Describe the types of resources and services needed to provide comprehensive treatment;
4. Note any treatment needs that may go unmet because formal resources and services may be unavailable to the child; and
5. Assess the child's and the family's environment for any hidden or untapped strengths or assets.

AS A GROUP,

Identify a facilitator and recorder for this group activity, and please:

1. Review the problems/issues identified and prioritize them;
2. Identify the array of services and resources needed to comprehensively treat the child and family (after problems and treatment needs have been agreed upon);
3. Describe any hidden or untapped strengths or assets associated with the child's or the family's environment; and
4. Have the recorder prepare to discuss your group's recommendations.

PROFILE: **Kisha**

Kisha is an 11 1/2 year-old African-American girl who came to the attention of your agency following a suicide attempt, during which she tied some cellophane over her head after having locked her stepmother out of the house. Paramedics found her comatose and rushed her to a metro-area hospital, where she was resuscitated and her condition stabilized. In the hospital, she was transferred to the psychiatric unit where she was well-behaved and made no further suicide attempts. She was given a primary diagnosis of Adjustment Disorder with Mixed Emotions and a secondary diagnosis (Axis II) of Borderline Personality. She was discharged from the hospital and placed in a temporary shelter, run by a private agency. The juvenile court awarded temporary custody to the agency and the responsibility for providing post-hospital care and reuniting Kisha with her father and stepmother.

Her future was uncertain and the duration of her stay in the shelter indefinite. Her natural parents (Robert and Cindy) divorced when Kisha was four years old, but have remained bitterly antagonistic--to the point where they were physically restrained and removed from the courtroom. Kisha lives with her father and stepmother while her brother, Dante, age seven, lives with his natural mother. Robert is reported to have stormed out of the house in an alcoholic, verbally abusive and physically violent rage when Cindy told him that she was pregnant with Dante. Kisha visits her natural mother, brother and stepfather but has to be supervised closely because she physically and emotionally abuses her younger brother.

Kisha is a large girl (5'8" and 130 pounds). She does well in school academically, but has few friends and underdeveloped social skills. She appears to be tolerated more than loved by her stepmother; her father (a long haul truck driver) is frequently out of the home. Her stepmother, Louise, works a 12-hour shift 5 days a week and is often burned out when she gets home late in the evening. Kisha's paternal uncle, Wilbert, typically invites Kisha to his house in the evening as an informal afterschool arrangement, which has been going on for the past 5 years. Little is known about Kisha's natural mother (Cindy) and her mother's second husband (Ralph). Kisha says that she enjoys the time she spends with them and the time she spends with her uncle Wilbert.

Kisha's desire to spend more time with her mother is blocked by her inability to get along with Dante. She is unable to spend much time with her uncle because he is a single man who dates frequently and spends a lot of time in the outdoors. The issue of where she spends her time is seen as secondary to her need for both physical and emotional closeness. Since her natural parents are mutually hostile, Kisha has been able to play both ends against the middle to create a great deal of friction.

Kisha could benefit from contact with other children her age, but she also needs a significant adult role model who has time (or makes the time) to interact with Kisha outside of school. Currently, Kisha is at a 60-day shelter in which she has made few friends, and has not attempted or even talked about another suicide attempt. When school is out for the summer, a large part of Kisha's day will be unstructured. Meanwhile, her natural parents blame each other for her behavior.

Kisha attends public school, but is not in a special education program. The school social worker was involved with the family until Kisha's placement, but has had trouble since then in reaching other providers or getting current information. The school social worker is one of the few people who can convene Kisha's natural parents without the meeting turning into an argument. The shelter program currently transports Kisha to and from school, but has had no formal contact with school personnel. The minister of a local church (where both Kisha's natural parents have attended for some time) has worked with the family since the suicide attempt, but he has not been involved in treatment planning or service delivery.

PROFILE: Gary

Gary is a 16-year-old white male with an 18-year-old sister. His 32-year-old half brother (same father, different mother) has recently returned to town after 15 years in the Navy. Gary's mother lives in a small town with her husband of 5 years. Gary has not had contact with his natural father, who currently resides in New Mexico. Gary's mother has been married three times, generally to alcoholic and abusive men. Between August 1986 and March 1987, Gary ran frequently, began using

drugs and alcohol, and was often aggressive. At this time, Gary was attending a special education program for academics and behavior management. The reason Gary was brought to the attention of your agency was because he threatened to kill his stepfather with a kitchen knife. The stepfather presented an ultimatum to Gary's mother and threatened to leave if Gary remained at home.

Upon the stepfather's urging, Gary was admitted as an in-patient at a local hospital psychiatric evaluation unit in March 1987. Gary was diagnosed as depressed; he was referred and accepted at a residential treatment center (RTC). While at the RTC, his mother divorced his stepfather and she became disruptive in the treatment program. Gary was eventually removed from the RTC for aggressive behavior.

Gary wanted to live with his half brother, who has recently taken an interest in him, or with his sister after she moves out of the home. The staff at the RTC wanted Gary to have "time out" in a nearby shelter home, but no slots were available and he was returned home.

During this period at home, mom began to see Gary as "no good", and blamed him for her recently failed marriage; she set him up for failure by goading him into overdosing on his antidepressant medication. After a brief stint in the hospital to determine the correct dosage, he was returned home. After one-and-a-half months at home, Gary's mother kicked him out.

Gary went to stay with his half brother, who revealed to Gary's mother that Gary was staying with him until she wanted him back home. She stated that the half brother, Andy, should do what he liked, but she would not allow Gary to return home. Andy tried to enroll Gary in the nearby neighborhood school's special education program, but the school's resource center refused to admit him. He was placed in an alternative high school, but was soon expelled for aggressive behavior. Since his expulsion in February 1988, he has had a home tutor and has been referred to two day treatment programs. One refused him and the school social worker has no word on the other referral.

Andy wants to assume custody of Gary, but recognizes the emotional problems and does not want custody if he cannot provide the proper support. Andy has been very supportive of Gary and has involved him in counseling at a neighborhood youth service center.

Gary's relationship with his mother is ambiguous; she loves him, but does not want him to return home. His sister would like to see him, but this is not supported by the mother.

Andy is afraid that he will lose Gary and that your agency will frown on him as a foster parent because he received a less than honorable discharge from the military. Gary is anxious because he thinks the only link to his father will abandon him. Gary has not used drugs or alcohol while with Andy, but has threatened to begin using again. Andy has two immediate objectives: (1) to keep Gary in his custody and off drugs; and (2) to get Gary in an appropriate high school special education program. The neighborhood school will readmit Gary if he successfully completes a treatment program; the school's special education liaison and Andy have developed a good working relationship. Andy plans for Gary to find a job this summer to constructively occupy his time and learn job skills. Gary's sister has offered to help, but Andy is uncertain as to how to use her assistance, except to provide emotional support for Gary over the next few months.

TRAINER NOTES

After reading the vignettes in the previous exercises, begin to identify elements needed in the case level system of care to make life more manageable for the child or youth, his or her family, and those working on their behalf. It is important to think in terms of the needs of the child and family, rather than of the services available. This section includes generic and blank concentric-circle diagrams, upon which trainees can jot down specific system of care elements. Examine the case level initially, but develop the organizational and interagency levels if time permits. Start by identifying elements that are needed, including those that could be developed from the child's natural network of support.

In identifying strengths, do not overlook the child's or family's natural network of support. Often racial and cultural groups depend upon natural networks, which may guide them to formal providers. For example, if we are dealing with Latino or African-American youth, the role of the church can be pivotal for emotional support and guidance; generally the extended family may be a source of support or strength, for groups of color.

If time permits, it may be possible to determine who to approach in the formal and natural networks to participate in either treatment planning or service delivery. Again, culture may be viewed as a hidden source of strength and support. Use the enablement plan (Figure 3).

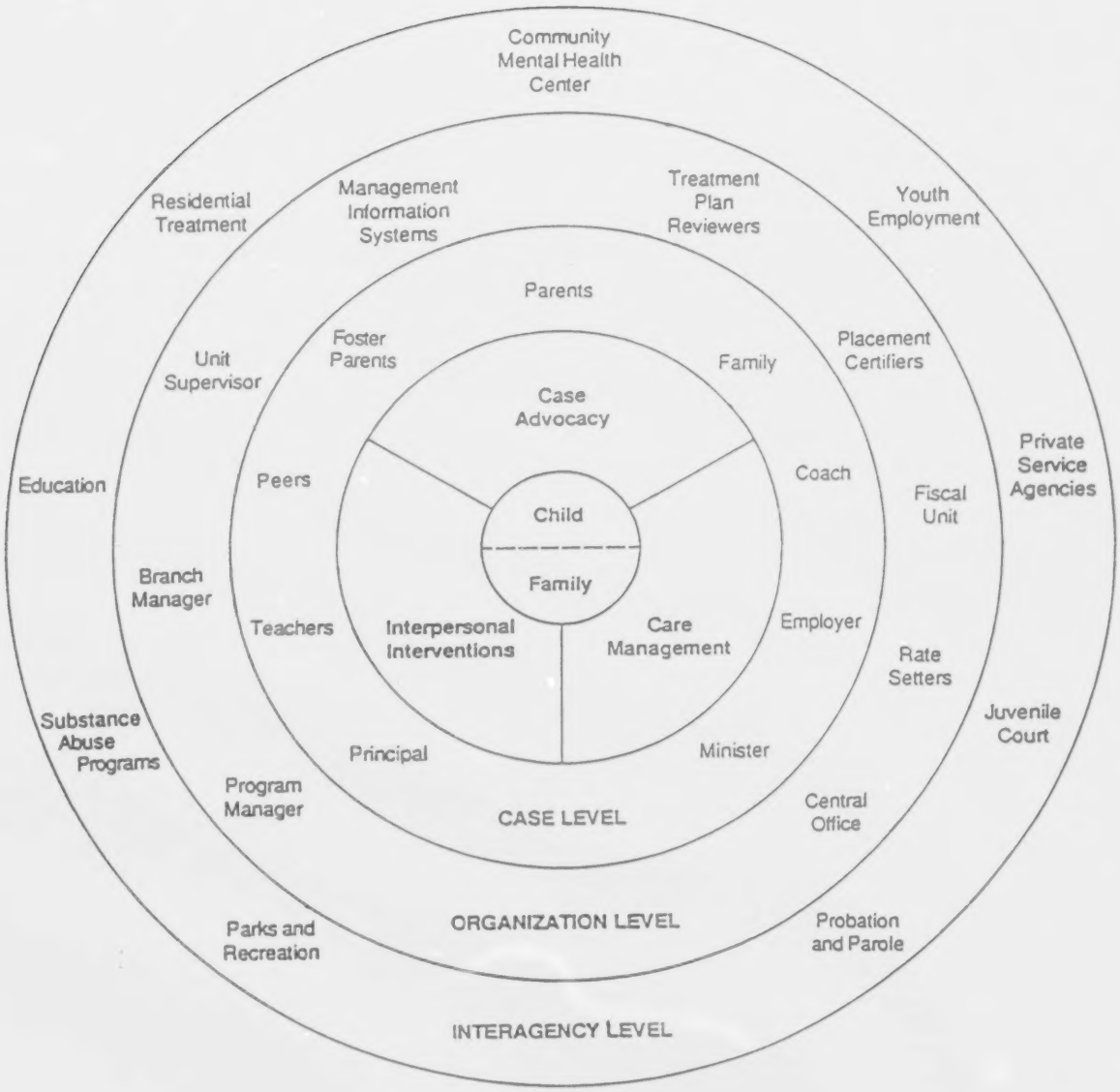

Community Mental Health Center
Residential Treatment
Management Information Systems
Treatment Plan Reviewers
Youth Employment
Parents
Foster Parents
Family
Unit Supervisor
Placement Certifiers
Case Advocacy
Private Service Agencies
Education
Peers
Coach
Fiscal Unit
Child
Branch Manager
Family
Teachers
Interpersonal Interventions
Care Management
Employer
Rate Setters
Substance Abuse Programs
Juvenile Court
Principal
Minister
Program Manager
CASE LEVEL
Central Office
Parks and Recreation
ORGANIZATION LEVEL
Probation and Parole
INTERAGENCY LEVEL

FIGURE 1

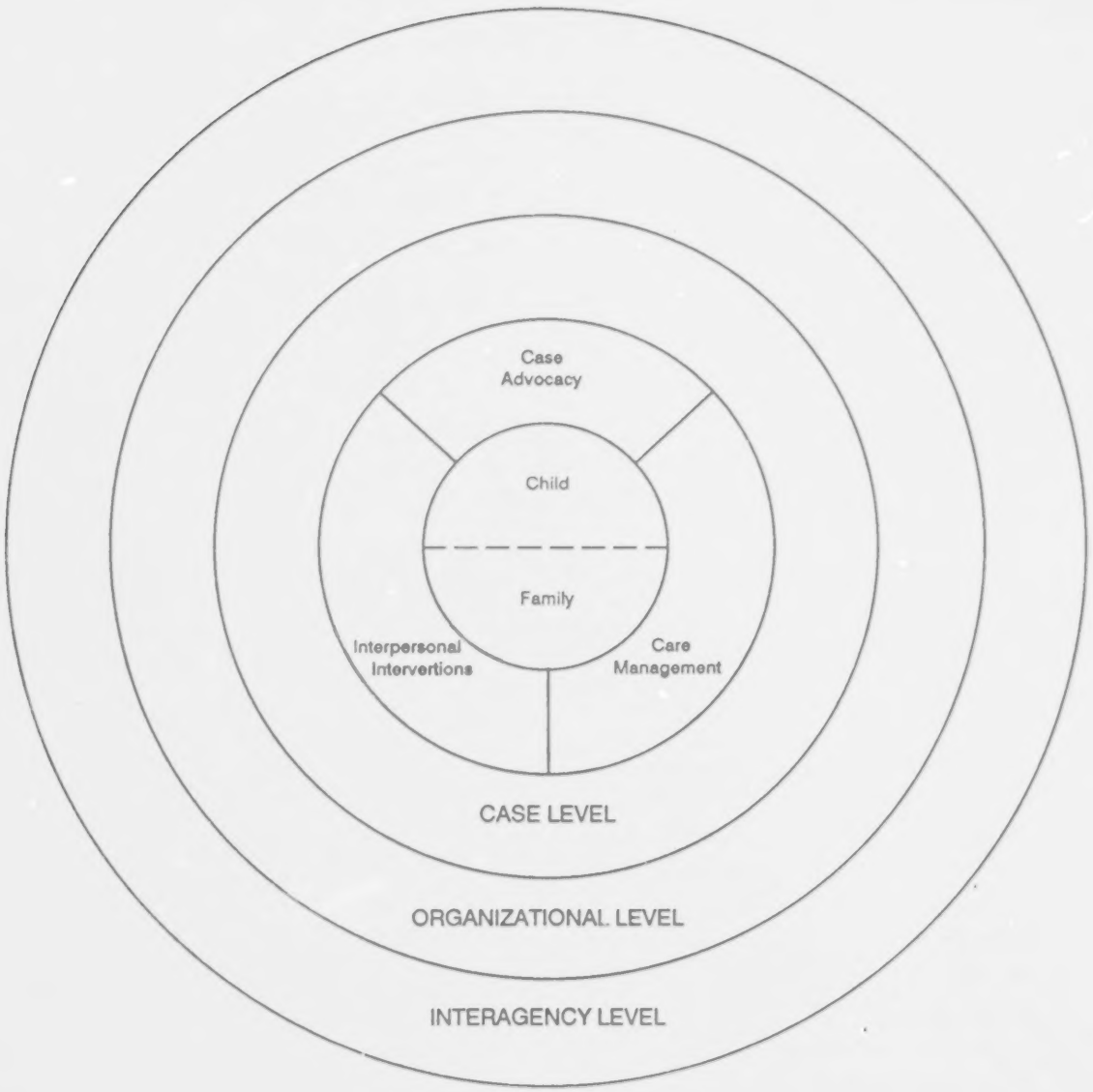

Case
Advocacy
Child
Family
Interpersonal
Intervertions
Care
Management
CASE LEVEL
ORGANIZATIONAL LEVEL
INTERAGENCY LEVEL

FIGURE 2

ENABLEMENT PLAN

Name/ID Number: _____ Date of Plan: _____

Worker/TCAdvocate: _____ Date of Review: _____

Service Required	Agency Responsible?	By Whom?	By What Date?	At What Cost?	Source of Funds	Criterion	Follow-up?

Figure 3

ACTIVITY III TRAINING GOAL:
Resource Identification and Development

OBJECTIVE

To identify or develop resources to create a comprehensive case-level system of care that includes natural networks of support as well as formal reviews.

ASSUMPTIONS

1. In recent years, there has been a reduction in the availability of human services. This is probably most acute for children and families who could benefit from "concrete" or other support services.

2. The reduction of formal services requires professionals to identify, access and utilize resources and supports in the natural helping networks, available to the child, family or community.

3. Natural helping networks are also behavior settings that must be modified to best reflect the capacities of the child in terms of expectations and provision of instructions, supports and rewards.

DISCUSSION

Current economic trends have led to a reduction in government spending, which has diminished the number and types of services available. This has emphasized the need to help families utilize natural helpers that exist in many communities to complement the formal provision of services.

Natural helpers and networks cannot operate independently from the formal-care network. In fact, as ways of modifying formal environments are developed to best help the child, natural networks of support must be modified to be consistent with formal-care networks. When the formal-care networks and natural-helping networks are aligned, the system of care is more responsive, comprehensive and individualized in design. A case level system of care can be created to provide the child and family with "normalizing" experiences, peer networks and supports.

Many professionals do not have the luxury of searching the community for natural support networks or to assess community strengths and assets. In some cases, professionals have not been trained or sanctioned to use natural networks, or to expend the time and energy to discover them. Historically, these natural networks of support have been seen as viable in racial, ethnic or cultural minority populations and in their communities, yet they hold potential for children and their families generally.

These natural networks often are genuinely concerned about children because they and their families are seen as resources to a community. Moreover, formal service provision (i.e., therapeutic intervention) must be reinforced by and upheld in all behavior settings, including ones involving the natural helpers.

Parents and family members are often the key to identifying a natural helping network; however, clergy, close friends, fictive or pseudo-kin, and neighbors may be helpful in this regard. Ideally, these networks are identified. Parents may be reluctant to turn to natural helpers because in doing so may create feelings of guilt, inadequacy, or fear of rejection.

In turn, many natural helpers may feel inadequate or reluctant to participate. Professionals have the advantage of knowing the field and of being able to cut through jargon or lofty language. Natural helpers can benefit greatly from an orientation regarding the disorder or diagnosis, prognosis and service plan. This can be facilitated by workshops, seminars, literature, or interaction with learned professionals. Perhaps this is an example of the adage "a little knowledge is dangerous," in that insufficient preparation may lead natural helpers to digress from the overall plan of action. As often as possible, natural helpers should be involved in the planning process.

To have a positive impact, natural helpers will need to know whom to call in the event of emergencies, crises or other unanticipated issues. Once properly prepared, natural networks of support can be used as: (1) potential elements in a case level system of care, and (2) possible behavior settings to reinforce therapy or other interventions. Natural supports are untapped resources that can potentially provide "concrete" services, including: transportation, respite, mentoring, emotional support, companionship, child care, recreation and a host of other services.

EXERCISES FOR ACTIVITY III:
Resource Identification and Development

In Activity II, systems of care were developed for Gary and Kisha, using formal resources and services. From the vignettes provided, consider the informal and natural networks of support that could be used to augment these formal systems of care.

INDIVIDUALLY,

Review your notes regarding unmet service needs and assets in the environment, and:

1. Consider ways in which natural supports could be used to complement the system of care;

2. Identify parents, family members, or significant others who can assist with:

   - advocacy;
   - information gathering;
   - parent, sibling, or family support;
   - meetings with the service team; and
   - other services and resources outlined by the assessment process.

3. List community-based organizations (e.g. churches, youth organizations, advocacy groups, volunteers, associations, etc.) which may afford the child and family normal socializing experiences or an enhanced quality of life.

AS A GROUP,

1. Identify a facilitator and a recorder.

2. Review your notes from the discussion questions above.

3. Develop ways in which informal or natural supports can be used to make the system of care more comprehensive.

4. Report your recommendations to the group.

TRAINER NOTES

It may help to have a mini-discussion regarding the trainees' natural supports and the ways in which these supports were identified, are maintained, and have proven to be helpful. If the emphasis is on providing a minimum of services for a child or family, natural helpers may not be needed. If the emphasis is on providing services and resources needed to maintain child and family, it becomes apparent that these needs may not be met through a traditional mental health treatment approach. The use of natural supports, when used in conjunction with the model, simply offers a wider array of services.

The system of care was discussed in the preceding chapter, and recorded on the concentric-circle diagrams. The goal of this section is to identify the types of services needed in a given situation. Sometimes it may be difficult to get a sense of realism from a vignette, and it may be necessary to use a real client. In this case, it will be important to heed issues of confidentiality. The vignettes were designed to imply that the child or family has a natural support network or belong to a community that has natural helpers.

If all needs are being met (as identified on the concentric circle diagrams) there are other considerations. For example, a planning unit may want to build in "normalizing," socializing or skill development activities. Some of these may include: recreation, family outings, trips, or social club involvement (scouting, 4-H, Special Olympics, trips to zoos and museums). Vocational training, work experience, tutorial services, substance abuse information, safe sex practices, or positive peer development activities may also be important "normalizing" and skill development activities. The goal in using natural supports is to complement the formal provision of services by enhancing quality of life and filling unmet needs.

To foster discussion, self-disclosure may prove helpful. In presenting this aspect of the model, discussion could center on supports that helped maintain our mental health as children and youth, (peers, extended family, hobbies, ambitions, accomplishments, and in the opportunity to contribute to others through volunteerism.)

Brainstorming is particularly helpful for this aspect of training. Workers typically develop the "Cadillac" or "Mercedes" type system of care, based on services that will actually help the child and family, rather than those that are available. In some instances, the menu of services and resources will have to be prioritized.

ACTIVITY IV TRAINING GOAL:
Applying the Components of the Model

OBJECTIVE

To help workers understand the skills necessary to effect and maintain changes in the expectations, instructions, supports, and rewards given to the child. These skills are applied at three levels of activity in working with the child and family, the worker's own agency, or on an interagency level.

ASSUMPTIONS

1. In direct work with the child and family, interpersonal interventions may be necessary to help the parents overcome feelings of frustration, failure, hopelessness, anger, or resentment in order to consider the resources available to their child and the options in their own "personal community" of friends, neighbors, and relatives. The child may also need interpersonal intervention to overcome feelings of distrust, fear, resentment, and anxiety, and to actively participate in designing the components for the system of care.

2. Advocacy on behalf of the child vis-a-vis the parents, and vice versa, should be anticipated as a normal need. Children who have an emotional disability and their parents are often sources of frustration, disappointment, and anger for each other. Facilitating communication within the family may be an initial step in working together. However, the Therapeutic Case Advocate will usually be speaking for both child and parents to representatives from other organizations (e.g., mental health clinics, juvenile courts, public schools, churches and recreational programs). The purpose of advocacy is to persuade other service providers to collaborate in designing, developing, and sustaining a system of care for the child and family.

3. Care management at the case level involves repeated monitoring and modification. This is a pluralistic process, in which the child, family, and participants from formal and natural support networks meet as a group with the Therapeutic Case Advocate to assess the adequacy of the system of care. Inevitably, the configuration of this system will change over time, as the child's and other family members' needs change.

DISCUSSION

In applying case advocacy, interpersonal interventions and care management to direct work with the child and family, four characteristics of each behavior setting must be examined: expectations, instructions, supports and rewards. If these are not compatible with the child's own ambitions, goals, given talents, and evolving skills in that context (Kohut, 1977), then the setting is contributing to the child's emotional

disability. If the setting adjusts expectations to the child's ambitions, provides support in attaining goals, offers instruction based on the child's talents and skills, and rewards each attempt to improve or acquire additional skills, then the characteristics of the setting have been modified to be more manageable for the child. To the extent that these modifications help the child acquire greater competence in the setting and bolster his or her sense of self as a vigorous and productive center of the initiative, the setting becomes less emotionally troubling to the child.

The Organizational Level

At the organizational level, case advocacy skills may be used in seeking exceptions to certain administrative rules and regulations to obtain the resources necessary to support the system of care. For example, one worker appealed her agency's upper limit for foster care payments so that a foster father could spend more time at home in the late afternoon, helping an adolescent with an emotional disability with his school work. The worker's success was based in part on her ability to demonstrate that the foster father could not take time off from work without the payment increase for foster care; the child would have had to attend a day treatment program at much greater expense to her agency.

Interpersonal intervention skills can also be useful at the organizational level. In the case example just described, the worker used the meeting with the TCA Unit to discuss her own frustration with the agency's policy and cumbersome appeal process. The group helped her redirect that energy into formulating a strategy for appeal. She was able then to elicit her supervisor's support by recognizing his personal reluctance to "rock the boat" and she presented the appeal herself.

The application of care management skills at the organizational level requires a commitment to the system of care concept and a tolerance for change over time. This concept involves meeting with representatives within and outside the organization to coordinate activities, review their progress against initial goals, and change their response according to the needs of the child and family.

The mechanics of care management can become tedious and burdensome if they are viewed as just paperwork (e.g., multiple telephone calls to arrange mutually convenient meeting times, location of a suitable and easily accessible space to meet, preparation of progress reports). Involving other members of the organization in this process is important because this allows the caring aspects of the entire group to be kept primary and makes the organization's response to unanticipated crises more human.

The Interagency Level

Once a worker has engaged the child and family in defining the elements needed in a system of care, and developed the support of his or her work group and agency, workers from other agencies can be engaged. Other agencies and staff are usually delighted that someone is willing to take responsibility for organizing, orchestrating, and coordinating their efforts. Collaboration is a welcome solution to the burden of feeling solely responsible for a complex situation without adequate resources. Staff working with children who have emotional disabilities and their families know only too well that their clients' needs exceed their agency resources.

For initiating interagency collaboration, the three components of the model can also be applied. Case advocacy and interpersonal intervention skills may help persuade supervisors or directors at other agencies to permit staff participation. The initiating worker may discover a price for participation: a telephone call, a meeting and written assurance that the activity has been approved by the worker's agency. The intent is to minimize duplication and counterproductive overlap of services.

Some care management skills may be applicable at the interagency level to help sustain the system of care and modify it as needed. Once interagency collaboration is set in motion, the initiating worker may use care management skills to evaluate participation. This may include discussing and clarifying roles, time constraints, and unexpected obstacles. In effect, the care management component of Therapeutic Case Advocacy extends beyond the child and family to the care providers.

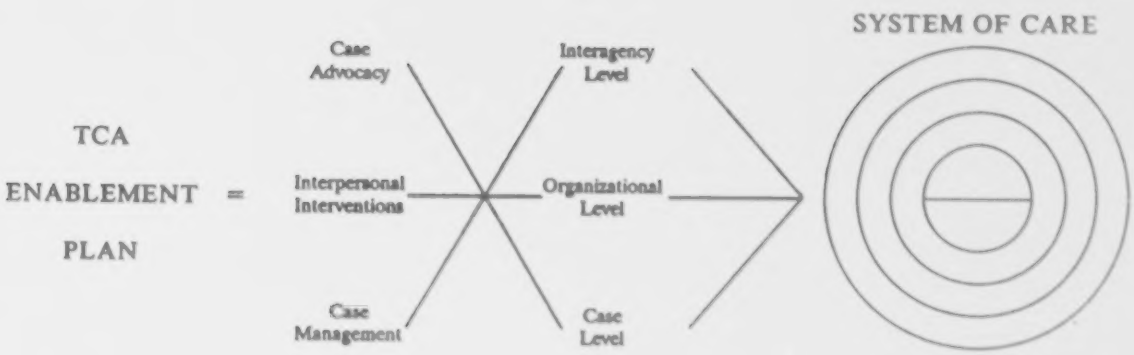
EXERCISES FOR ACTIVITY IV:
Applying the Components of the Model

THE TCA COMPONENTS

A. *Case Advocacy Skills* are used to modify the expectations, instructions, supports, and rewards provided by others in each behavior setting included in the system of care.

B. *Interpersonal Interventions* are used for two purposes: (1) to help the Therapeutic Case Advocate understand the child's and family's difficulties from each perspective; and (2) to elicit their cooperation as participants in designing a system of care. These interventions are also used with individuals in the child's or family's formal and natural support networks.

C. *Care Management Skills* are used to adjust the system of care to fit the child's and family's needs as they change and to transfer successful modifications in expectations, instructions, supports, and rewards from one behavior setting to another.



PROFILE: Mike

Mike is a 15-year-old, who was initially brought for treatment by his mother because of a combination of phobic behavior and hoarding food. The phobic behavior also involved food; he would not eat or drink from any container that he thought had another family member's germs on it.

He is the second of four children. He has an older brother, Cal, age 17, who left home following a period of substance abuse, treatment, relapse, and recovery. Mike also has a younger sister, age 12, and brother, 10, who appear mildly depressed but are not symptomatic.

Mike lives with his biological mother, Eva, and stepfather, Vince. Eva has a history of manic depression dating back to her high school years. She has been treated since before Mike was born and has achieved affective stability for the past six years with the help of 150 mgs. of Imipramine. Vince is recovering from alcoholism; he has been clean and sober for three years.

Mike has been a rather consistent underachiever in school. His performance deteriorated in high school because his teachers took more for granted than his middle school teachers. Mike's scholastic performance also suffered because he was singled out and "terrorized" by a sophomore, who threatened to hurt him and was known to possess a handgun.

Mike's behavior at home became more sullen and provocative, particularly toward his mother. This culminated in a shouting match in which he called her a terribly derogatory and insulting name. This enraged Vince, who threatened to kick Mike out of the house. Mike dared him to do so and he did kick him out the front door and off the front porch. Following this incident, they sought placement for Mike through the public child welfare system.

TRAINER NOTES

Therapeutic Case Advocacy components have been difficult for some people to grasp. Typically, this difficulty has been more a product of the terminology than the actual behaviors. Discussing or renaming the behaviors, or offering clear examples may aid in comprehension. The goal is to begin using the TCA components, rather than becoming fluent in component terminology.

It might be helpful to use the same case examples used for Activities II and III in Activity IV. As an aid to the trainer, this section contains an expanded description of the components to operationalize some of the concepts to facilitate the trainees' grasp of the principles.

QUESTIONS FOR DISCUSSION

Case Advocacy

1. What are the underdeveloped areas in Mike's life?

2. In what ways do you think expectations, instructions, supports and rewards could be modified at school?

3. How would you "make it safe" for Vince to modify his behavior toward Mike?

4. What is the basis for your leverage in this situation?

5. Suppose attempts at family therapy did not work and it appeared likely that there would be a repetition of the physical violence between Vince and Mike. What would your contingency plan be?

Interpersonal Interventions

1. What was Vince's rage reaction about?

2. How do you understand Mike's phobic behavior and underachievement?

3. How would you translate the psychological needs of both Mike and Vince into plans for modifying their respective environments? (Specify in terms of behavior setting(s) and the expectations, instructions, supports, and rewards.)

4. How would you proceed to construct a system of care with this family? (Specify steps for each behavior setting.)

5. What reactions do you think people will have?
   a. child and family?
   b. other providers in the system of care?

Care Management

1. Who would you seek to involve as members of the TCA Service Team?

2. How would you involve Eva, Vince, and Mike?

3. Who would best serve as case manager?

4. What would a support system for the providers look like? How would it work?

5. How would you carry out a formal evaluation of the system of care?

COMPONENT NO. 1: CASE ADVOCACY

Principles:

1. The primary, over-arching goal is to create a system of care that surrounds and supports the child and his family on a daily basis.

2. The "targets" of case advocacy efforts are also people. Nothing is to be gained by declaring them enemies; advocacy can be partisan without being adversarial.

3. Child and family involvement is essential in all aspects of the advocacy process, so that one result of advocacy is an enhanced capacity to speak for themselves.

Skills: To be able to...

1. Identify "target areas" within an ideal system of care.

2. Define resource development needed for each behavior setting in the system of care.

3. For each behavior setting, locate individuals who could provide alternative instruction, support, and reward for the child and/or family.

4. Acquire the history of previous interactions between child/family and potential providers.

5. Use the process of assessing the discrepancy between child/family needs and services currently provided, to forge a personal relationship between you and the provider.

6. Analyze the personal costs of modifying the instructions, supports, and rewards in each behavior setting.

7. Specify your basis for exerting leverage in the situation.

8. Consider the effect of timing in requesting alternative instruction, support and reward.

9. Formulate and prepare contingency plans in the event that a crisis develops between child/family and provider.

10. Propose, persuade, or entice potential provider to try alternative instruction, support, and reward.

COMPONENT NO. 2: INTERPERSONAL INTERVENTIONS

Principles

1. The primary, over-arching goal is to engage and sustain the child and family in the process of working out a new accommodation between them and their environment.

2. Interpersonal interventions serve case advocacy and care management efforts to establish and maintain a system of care, not vice-versa.

3. The use of interpersonal interventions is not synonymous with providing psychotherapy. Interpersonal intervention involves work with both the client and with others in the client's environment.

Skills: The ability to...

1. "Listen with a third ear" for issues that others would like to discuss but feel they cannot.

2. Absorb verbal abuse and aggression in response to the offer of help.

3. Understand and describe one's own feelings directly.

4. Acquire an empathic comprehension of another person's difficulties and convey empathy in words and gestures.

5. Translate a person's psychological needs into plans for enhancing, restructuring, or modifying provision of instruction, support and reward.

6. Clarify one's own role and the purpose of the relationship.

7. Separate a large problem or issue into manageable and meaningful tasks, which can be performed sequentially.

8. Encourage repeated feedback on the helpfulness of the relationship and the process of accomplishing tasks.

9. Anticipate the demands that new accommodations will bring for children, parents, and their environments. Devise opportunities for respite and reward as part of the process of constructing the system of care.

10. Set enforceable limits on the behavioral expression of anxiety, impatience, frustration, or anger, and negotiate the consequences for exceeding those limits.

COMPONENT NO. 3: CARE MANAGEMENT

Principles

1. The primary, over-arching goal is to coordinate, integrate and maintain a network of services that establish and support a functioning balance between child, family and their environment.

2. The guiding idea behind care management is the routinization of an individualized system of care that remains flexible and adaptive over time as needs and circumstances change. Accountability is ultimately to the child and family.

3. The process of care management is more important than the product. By definition, the process is individualized, interactive, and pluralistic.

Skills: The ability to...

1. Assemble the people involved in each of the child/family's behavior settings to design the individualized system of care and to determine each person's contribution (the TCA service team).

2. Involve the child and family in the process and verify mutual understandings and expectations.

3. Define goals for each component of the system of care to use in evaluating progress.

4. Select a care manager from among the members of the TCA service team.

5. Review plans for modifying the provision of instruction, support, and reward in each behavior setting and establish a time/task chart to record the team member(s) responsible for tasks and timelines for completion.

6. Schedule meeting time(s) and place(s) for subsequent reviews and modification of the plan.

7. Devise measures of satisfaction for the child, parents, and each of the constituent members of the system of care.

8. Devise a system of 24-hour response capability for crisis intervention, preferably rotating responsibility among team members.

9. Create support system(s) for providers in the system of care.

10. Evaluate the system of care from the consumers' and providers' perspectives.

CASE ADVOCACY: AN EXPANDED DESCRIPTION

1. Identify target areas in the ideal system of care.
   a. The presenting problems (e.g., home and school behavior).
   b. Underlying issues (e.g. peers, employment, extended family).

   Note: It may be helpful to think about the child/youth's use of time during the day, evenings, and weekends.

2. Define the resource development tasks for each area.
   a. How should the expectations, instructions, supports, and rewards in each area be changed to fit the child/youth's capabilities?

3. Locate individuals who can provide alternative expectations, instructions, supports, and rewards in each area.
   a. Avoid opposing negativism.
   b. Prepare these individuals for their role.

4. Pursue the history of any prior attempts to change in these areas.
   a. With child/family.
   b. With provider.

5. Make changes in a safe, non-threatening way.
   a. With child/family.
   b. With provider.

6. Analyze the price structure and make it explicit to team members.
   a. Monetary.
   b. Other costs.

7. Clarify the basis for your leverage in the situation.
   a. Legal authority.
   b. Consensus authority.

8. Consider the importance of timing.
   a. With child/family.
   b. With provider.

9. Prepare contingency plans.
   a. With child/family.
   b. With provider.

   Note: This involves asking questions such as: how can effectiveness be evaluated at each major step in carrying out the plan? What can be done if the plan is failing?

10. Implement the plan.

INTERPERSONAL INTERVENTIONS: AN EXPANDED DESCRIPTION

1. Listen with a "third ear."
   a. For when anger masks fear.
   b. For when talk avoids communication.

2. Absorb verbal aggression.
   a. As a test of you.
   b. As part of assessment.

3. Understand and describe one's own feelings directly.
   a. With yourself.
   b. With client.
   c. With other providers.

4. Acquire empathic comprehension.
   a. With client.
   b. With other providers.

5. Translate psychological needs into plans for modifying environments.
   a. Analysis of interactions in each behavior setting.
   b. Client participation in planning.

6. Clarify your role and purpose: designer/facilitator of a system of care.
   a. With yourself.
   b. With child and family.
   c. With other providers.

7. Describe steps to be taken for modifying expectations, instructions, supports, and rewards in each behavior setting.
   a. Small, realistic goals.
   b. Incremental change.

8. Establish a feedback process before changes are made.
   a. With child and family.
   b. With other providers.
   c. Feedback regarding tasks and your relationship with the team and the child.

9. Anticipate new demands arising from modifying the environment.
   a. On child and family.
   b. Realistic expectations.

CARE MANAGEMENT: AN EXPANDED DESCRIPTION

1. Assemble the players.
   a. Selection.
   b. Preparation.

2. Involve the child and family.
   a. Parents.
   b. Child.
   c. Others.

   b. Child.

3. Set goals for each behavior setting.
   a. Achievable.
   b. Meaningful for all parties.

4. Select a case manager.
   a. Role and authority.
   b. Selection process.

5. Implement System of Care Plan.
   a. Review plans for modifying expectations, instructions, supports, and rewards.
   b. Construct time/task/assignment chart.

6. Set date, time and place to review progress.

7. Devise measures of satisfaction.
   a. Child.
   b. Parents.
   c. Providers.

8. Establish plan for 24-hour response capability.
   a. Use existing emergency resources.
   b. Create individualized plan based on other resources available to the child/family.

9. Create support system(s) for providers in the system of care.
   a. Process of developing supports.
   b. Implement plan.

10. Conduct a formal evaluation of the system of care.
    a. Child's perspective.
    b. Parents' perspective.
    c. Providers' perspective.

TRAINER'S NOTES: FINAL THOUGHTS

This perspective emphasizes the use of treatment activities to develop individual potential.

The disabling characteristics of a setting may be modified to make it more manageable for the child and less emotionally troubling. This can be achieved by modifying expectations to match the child's ambitions, providing support for attaining goals, giving instructions based on the child's skill level, and rewarding genuine attempts to improve skills.

For example, the stepfather in Activity II presented an ultimatum to Gary's mother and threatened to leave if Gary remained at home.

Facilitating communication within the family may be the initial step in working together.

Evaluation should address changes in the child's functioning and ways in which the process of care management can be improved.

Accountability and evaluation are two important aspects of the model that were not covered. It might be useful to discuss the ways in which trainee's agencies address issues of accountability and methods for evaluating client progress.

Typically, accountability and evaluation are measured in terms of agency or worker efficiency. Yet under TCA, the issues of consumer satisfaction (child, family and community) must also be considered. The issues and perspectives of the child and family are particularly important in evaluation. However, the perceptions and concerns of service providers must also be assessed.

Evaluation should address changes in the child's functioning and ways in which the process of care management could be improved. In some cases, agencies will have a mechanism to capture some of this information. If this is not in place, an information-gathering mechanism will have to be designed. As a strong suggestion, a process recording or process evaluation approach could be used to help refine the concept within a given agency or community context. It is advisable for workers to maintain a personal log to compare actual to planned activities and to suggest improvements.

At the end of this document are some suggested evaluation and data collection forms used by the Therapeutic Case Advocacy Project for pilot studies. They may serve as an example of the types of evaluative data that should be collected and analyzed. Of course, it may be necessary to modify the suggested forms, or to add or delete items to be more compatible with a specific program or service delivery model. To pilot such an approach and not evaluate its efficacy over time would not promote refinement of the model. Bear in mind, that is might be wiser to collect more data than you may ultimately need, because you may not have time to collect the data after the fact. In some programs the use of more standardized measures may suffice.

Explain that it is not unusual for workers to encounter some problems initially, so that they are not dissuaded by setbacks. The approach is an ideal model that has wide applications. Refining the model for a specific context occurs over time and results from perseverance, courage and the desire to provide a high quality of service delivery to children and youth with serious emotional disabilities, as well as their families. Good luck to trainers and trainees embarking on a difficult and rewarding experience.

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APPENDIX A

Evaluation and Data Collection Forms

DEFINITIONS OF IMPORTANT EVALUATIVE TERMS
Therapeutic Case Advocacy Project

1. EXPECTATIONS are ideas in an adult person's mind about what the child should do in the behavior setting. For example, in the behavior setting "home-at-bedtime," the adult might expect the child to wash, brush his or her teeth, find and change into sleepware, and get into bed.

2. INSTRUCTIONS are verbal directions to perform specific tasks and/or demonstration (by the adult) of what the child is supposed to do. Examples are, "Please wash the dishes with soap, rinse and dry them," or "Print your name at the top right hand corner of the page."

3. SUPPORT means personal help: being available to answer questions; checking to see if the child understands or is confused about what he or she is supposed to do.

4. REWARD is any form of positive reinforcement for desired behavior. A hug, verbal praise, and staying up later to watch a movie or TV are all examples of rewards that do not involve money or things. Other kinds of rewards are candy or money.

Prepared June 1988
Research & Training Center on Family Support
and Children's Mental Health
Regional Research Institute for Human Services

Tom Young, James Mason, Katie Yoakum, Fran Hart

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THERAPEUTIC CASE ADVOCACY

Purposes of the Evaluation

The main purpose of this evaluation is to find out whether use of the model, Therapeutic Case Advocacy, produces changes over time in the expectations, instructions, supports, and rewards of designated behavior settings within the child's environment. That is, does use of the model actually have any effect on what it intends to change? This question will be addressed by data recording the perceptions and judgements of significant adults in each behavior setting (yellow form), and compared with those collected from the child (blue form).

A second purpose is to find out whether changes in expectations, instructions, supports, and rewards are related to changes in self-esteem, depression, impulsivity, peer relations, locus of control, and attitude toward parents. That is, does modifying characteristics of the environment have any influence on the child's internal state? This question will be addressed with data from the rapid assessment instruments to be completed by the child at the beginning and end of the 90-day service period.

A third purpose is to assess the satisfaction of both staff and parents with the group processes necessary for use of the model. This involves three questionnaires: one for those who are members of the TCA Unit (pink) and one for those who are participants of the TCA Service Team (green). The third form (gold) is for parents only.

Frequency of the Evaluation

1. **Environmental Characteristics** (YELLOW): One for each behavior setting that is problematic.
   -Every 30 days.-

2. **Children's Questionnaire** (BLUE): One for each behavior setting that is problematic.
   -Every 30 days.-

3. **Evaluative instrument for Unit Participants** (PINK): One for each case.
   -End of Service Episode.-

4. **Evaluative instrument for the Service Team** (GREEN):
   -Once every 3rd meeting.-

5. **Satisfaction Survey for Parents** (GOLD): Once for each case.
   -End of Service Episode.-

THERAPEUTIC CASE ADVOCACY PROJECT
Evaluative Instrument
for Environmental Characteristics

TCA ID#_____ Case#_____ Child's Name:_____

Date:____/____/____ Respondent Name_____

1) What is your relationship to the child? _____

2) Describe the specific setting where the child shows problems in his/her behavior (e.g. "home: at bedtime", or "school: at recess").

_____

_____

_____

3) How would you describe the child's difficulties in this setting?

_____

_____

_____

QUESTIONS ABOUT EXPECTATIONS AND INSTRUCTIONS

4) What do you expect of the child in this setting?

_____

_____

_____

5) Do you feel that the child understands these expectations?

Not at all *Half the time* *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

6) How often is the child able to meet these expectations?

Not at all *Half the time* *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

7) How would you compare the expectations you have for this child to those you might have for other children in this setting?

___*I expect less from this child* ___*No difference* ___*I expect more*
___*I cannot rate*

8) What exactly are the instructions you give to this child?

_____

_____

_____

9) How often do you feel the child understands the instructions?

Not at all *Half the time* *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

10) Does the child need you to act out the instructions before s/he tries them?

Not at all *Half the time* *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

11) Do you find that you must repeat the instructions for the child?

Not at all *Half the time* *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

12) Is there anything else we should know regarding your expectations and instructions for this child?

_____

_____

_____

QUESTIONS ABOUT SUPPORT

13) Does this child seem to need help more often than other children in this setting?

Not at all *Half the time* *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

___I cannot rate

14) Does the child ask for help often?

Not at all *Half the time* *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

15) Are you able to stay near the child in case s/he wants help with the task?

Not at all *Half the time* *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

16) Who else provides help in this setting?

_____

_____

17) Other comments regarding support for this child:

_____

_____

_____

QUESTIONS ABOUT REWARDS

18) What are examples of rewards that you give to the child in this setting?

_____

_____

_____

19) When and for what are rewards given to the child?

_____

_____

_____

20) How often do you think the child understands what the reward is for?

Not at all *Half the time* *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

21) How often is the reward something the child really wants?

Not at all *Half the time* *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

22) Other comments on rewards:

_____

_____

_____

THANK YOU FOR COMPLETING THIS FORM. Further comments are welcome on back.

THERAPEUTIC CASE ADVOCACY
Children's Questionnaire

TCA ID#_____ Case #_____ Child's Name:_____

Date:____/____/____ Interviewer:_____

Instructions: This evaluative instrument should be completed by the child with help from a TCA Service Team member. This should take place when service begins and every 30 days thereafter.

The Behavioral Setting here is: _____

A. QUESTIONS ABOUT EXPECTATIONS AND INSTRUCTIONS

1) What do you think _____ expects of you here?

_____

_____

_____

2) How often do you understand what is expected? (please circle)

Never *Half the time* *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

3) How much are you able to do these things?

Never *Half the time* *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

4) Do you understand instructions about what you're supposed to do?

Never *Half the time* *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

5) What exactly are you told to do here--what are the instructions?

_____

_____

_____

6) Are there times when you want to watch someone follow the instructions before you try them?

Never *Half the time* *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

7) Do you remember instructions better when you hear them more than once?

Never — *Half the time* — *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

8) Do you ever feel like you can't follow the instructions because they're too hard to understand?

Never — *Half the time* — *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

9) Tell us about these or other reasons why you might have trouble doing what is asked:

_____

_____

_____

B. QUESTIONS ABOUT SUPPORT

10) Do you find yourself needing a lot of help here?

Never — *Half the time* — *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

11) Are you able to ask for help whenever you need it here?

Never — *Half the time* — *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

12) Does the person in this setting talk to you and help you when you need it?

Never — *Half the time* — *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

13) Does this person do what you are supposed to do along with you for the first few times?

Never — *Half the time* — *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

14) Does he or she stay near you in case you need help?

Never — *Half the time* — *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

15) Please tell us about other people who help you and the kinds of help you get here:

_____

_____

_____

C. QUESTIONS ABOUT REWARDS

16) What kinds of rewards do you get here?

_____

_____

_____

17) How often do you get rewards here?

Never *Half the time* *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

18) What do you get rewards for?

_____

_____

_____

19) Do you like the kind of reward you get when this happens?

Never *Half the time* *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

20) How long do you wait to get the reward?

_____

_____

_____

21) Is there anything else you'd like to say about rewards?

_____

_____

_____

THANK YOU FOR ANSWERING THESE QUESTIONS! If you want to say anything else, just use the remaining space on this form.

THERAPEUTIC CASE ADVOCACY
EVALUATIVE INSTRUMENT FOR UNIT PARTICIPANTS

TCA ID# _____ Case# _____

Respondent Name: _____ Agency: _____

Date: _____/_____/_____ Child's Name: _____

1) Have you participated in a TCA Unit meeting where this child's case was the focus of discussion? ___ *yes* ___ *no*

Please answer the following questions if you answered "Yes" above.

2) During this meeting, was your participation encouraged by the Unit Coordinator?
___ *yes* ___ *no*

3) How involved were you in formulating a service plan for this child during this meeting?
Not at all *Somewhat* *Very Involved*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

4) Were there arguments during the meeting among Unit members?
___ *yes* ___ *no*

5) Was the Unit coordinator able to effectively manage such conflicts?
(___ *doesn't apply*)
Not at all *Half the time* *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

6) Did you feel that your ideas were respected by Unit members?
Not at all *About half the time* *All the time*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

7) Were you satisfied, overall, with the process of choosing a service plan for this child?
Not at all *Somewhat* *Very Satisfied*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

Thank you for your input. Further comments are welcome.

UNIT MEMBERS ONLY

8) Have lines of communication between the unit and the service team stayed open regarding this case?

Not at all — *Somewhat* — *Always open*

0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

9) Have service team recommendations for change in plan or team membership been accepted by the unit? ___ *yes* ___ *no* ___ *doesn't apply*

10) In your opinion, to what extent was the service needs assessment for this child a multi-agency process?

Not at all — *Somewhat* — *Completely*

0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

11) Was the service plan formulation also a multi-agency process?

Not at all — *Somewhat* — *Completely*

0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

12) Has information concerning the child been shared in an efficient manner?

Not at all — *Somewhat* — *Very Efficient*

0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

13) How would you rate your organization's support of your involvement on the TCA work unit?

Obstructive — *Neutral* — *Extremely supportive*

0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

14) Please rate this support in comparison to that which you would receive for a non-TCA case of similar type: (please check)

	less	*same*	*more*
Administrative	____	____	____
Supervisory	____	____	____
Other staff support	____	____	____
Money for goods/services	____	____	____
Workload deduction needed to accommodate this case	____	____	____

15) Compared to a non-TCA case, how would you rate the amount of time you spent working on this case?

Much less — *Same* — *Much more*

0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

16) What effect has your involvement with the TCA Unit had on your job satisfaction?

Extremely negative — *No change* — *Extremely positive*

0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

Thank you. Comments are welcome on the back of this form.

UNIT COORDINATORS ONLY

17) How many agencies were involved in putting together the needs assessment and service plan for this child? _____

18) Who represented the child's family in this unit process?

_____

_____

_____

19) Who else represented the child's community?

_____

_____

_____

20) Did the unit identify administrative policies which needed exception in order to benefit this client? ___ *yes* ___ *no*

21) If "Yes," was the unit able to create and implement strategies toward such an exception? ___ *yes* ___ *no*

22) Please comment on these or other issues regarding your role as Unit Coordinator:

THERAPEUTIC CASE ADVOCACY
EVALUATIVE INSTRUMENT FOR THE SERVICE TEAM

TCA ID#_____ Case#_____

Respondent Name: _____ Agency Name:_____

Date: _____/_____/_____ Child's Name:_____

1) How often have team members shared information with you about this child? (please circle)

Never *Often enough* *Too often*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

2) Has your participation been encouraged by the service team coordinator? ___yes ___no

3) Do you feel that your ideas are respected by other members of the team?
___yes ___no

4) How often have your ideas been used or implemented by the service team?

Never *Often enough* *Always*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

5) Have there been arguments among service team members? ___yes ___no

6) How often have these situations been handled effectively by the service team coordinator?

Never *Half the time* *Always*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

7) When TCA Unit suggestions have been brought up, how clearly were they explained to the service team?

Unclear *Somewhat clear* *Very clear*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

8) In your opinion, how often are you and other team members able to reach agreement about expectations, instructions, support and rewards for this child?

Never *Half the time* *Always*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

9) Is the system of care by this service team proving to be helpful to this child?

No help *Somewhat helpful* *Very helpful*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

THANK YOU FOR YOUR INPUT. Your comments are welcome in the remaining space of this form.

FOR THE SERVICE TEAM COORDINATOR ONLY

Coordinator Name: _____ Case#_____

10) How often does this service team meet? _____

11) How many different **agencies** are represented on this team? _____

12) How often have service team members monitored the child's behavior and reported their findings to you?

Never *Often enough* *Too often*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

13) How helpful was the TCA unit in identifying members for this team?

Not at all *Somewhat* *Very helpful*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

14) Who represents the personal community of this child on the team?

_____

_____

15) How useful were TCA unit recommendations regarding a service plan for this child?

Not at all *Somewhat* *Very useful*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

16) Has the TCA unit been available to you for additional advice beyond their first recommendations?

Not at all *Somewhat* *Always Available*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6

17) Have TCA unit members been receptive to new information and perspectives from this service team? ___yes ___no ___doesn't apply

18) Has the TCA unit supported any recommendations by the service team for changes in its membership or service plan? ___yes ___no ___doesn't apply

THANK YOU FOR YOUR INPUT. Please comment on these or other issues related to your role as service team coordinator using the remaining space of this form:

TCA ID#_____ Case #_____

Date:_____/_____/_____

THERAPEUTIC CASE ADVOCACY PROJECT
Satisfaction Survey for Parents

Instructions: Please include today's date above and answer all questions on this form as they apply to your experience with the TCA Project. Comments are appreciated.

1. Did you want to participate in this TCA Project?

   ___*not at all* ___*some reluctance* ___*no opinion* ___*some interest* ___*great interest*

   Please comment as to why or why not:

   _____

   _____

   _____

2. Did you feel that the TCA Service Team treated you as an important person on the "team" working to help your child?
   ___*never* ___*sometimes* ___*half the time* ___*most of the time* ___*all of the time*

   Please comment on how you were treated by others on the TCA Service Team:

   _____

   _____

   _____

3. Were you able to make it to Service Team meetings without difficulty?

   ___*never* ___*sometimes* ___*half the time* ___*most of the time* ___*all of the time*

   Please list any problems you might have had getting to TCA Service Team meetings, and describe what would have made it easier for you to attend:

   _____

   _____

   _____

4. Were you able to get information, if needed, about programs and services through this project without difficulty?
   ___*never* ___*sometimes* ___*half the time* ___*most of the time* ___*all of the time*

   Comments:

   _____

   _____

   _____

5. Were you able to understand how this project works and where you fit in?

___*never* ___*sometimes* ___*half the time* ___*most of the time* ___*all of the time*

Comments:

_____

_____

_____

6. When you had suggestions or ideas, did you feel they were listened to and used to improve the situation?

___*never* ___*sometimes* ___*half the time* ___*most of the time* ___*all of the time*

How could the TCA Service Team have made better use of your ideas?

_____

_____

_____

7. Was being a part of the TCA Service Team helpful to you?

___*never* ___*sometimes* ___*half the time* ___*most of the time* ___*all of the time*

Comments:

_____

_____

_____

8. Were there any services that you or your child needed but did not receive from this project?

___*yes* ___*no* (please comment)

_____

_____

_____

9. As a parent, would you have liked an orientation or training class that could have helped you feel more like a peer within the TCA Service Team? ___*No* ___*Yes, see those checked below:*

*S.E.D. EDUCATION*___ *PARENT SUPPORT GROUP*___ *ASSERTIVENESS TRAINING*___

*UNDERSTANDING SOCIAL SERVICE AGENCIES*___ *COMMUNITY RESOURCES*___

*OTHER*___:_____

10. Do you feel you have a greater understanding of your child as a result of being part of this project?

_____*not really* _____*somewhat* _____*definitely*

Please comment:

_____

_____

_____

11. Do you feel you have a better understanding of what was done with and for your child in this project?

_____*not really* _____*somewhat* _____*definitely*

Please comment:

_____

_____

_____

Thank you for all your efforts with this project and this survey. If you have any further comments or suggestions, please use the following space to do so.

THERAPEUTIC CASE ADVOCACY TRAINERS' GUIDE

EVALUATION FORM

1. Who used the *Therapeutic Case Advocacy Trainers' Guide*? (Check all that apply.)

   ___Parent ___Educator ___Child Welfare Worker

   ___Juvenile Justice Worker ___Mental Health Professional

   Other (Please Specify)_____

2. Please describe the purpose(s) for which you used the *Trainers' Guide*:

   _____

   _____

   _____

3. Would you recommend use of the *Trainers' Guide* to others? (Circle one)

   Definitely Maybe Conditionally Under No Circumstances

   Comments:_____

4. Overall, I thought the *Trainers' Guide* was: (Circle one)

   Excellent Average Poor

   Comments:_____

5. Please offer suggestions for the improvement of subsequent editions of this *Trainers' Guide*:

   _____

   _____

   _____

   _____

   _____

We appreciate your comments and suggestions. Your feedback will assist us in our effort to provide relevant and helpful materials. Thank you.

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